BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

DEBORAH ANN BEARCE	)	
Claimant	)	
	)	
VS.	)	
	)	
UNITED METHODIST HOMES	)	
Respondent	)	Docket No. 1,012,909
	)	
AND	)	
	)	
KANSAS ASSN. OF HOMES FOR	)	
THE AGING INS. GROUP	)	
Insurance Carrier	)	

ORDER

Claimant requested review of the July 26, 2006 Award by Administrative Law Judge (ALJ) Brad E. Avery. The Board heard oral argument on November 15, 2006.

APPEARANCES

Paul D. Post, of Topeka, Kansas, appeared for the claimant. Michael L. Entz, of Topeka, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ concluded that the claimant sustained a 2 percent functional impairment as a result of her September 27, 2000 accident based upon the opinions of the independent medical examiner, Dr. David Clymer. In addition, the ALJ denied the

claimant's request for additional temporary total disability (TTD) benefits as he found there was no support in the record for that request.[1]

The claimant requests review of this decision alleging she is entitled to both a work disability under K.S.A. 44-510e(a) for the aggravation of her preexisting condition as well as an additional 40.72 weeks of TTD for the time she was off work for back surgery. The claimant maintains the evidence supports her claim for a 28.85 percent work disability, which is comprised of a 26 percent task loss and a wage loss of 31.7 percent. Claimant also argues that the report and deposition of Dr. Steven Hendler should be stricken from the record and not considered because Dr. Hendler considered accident reports which are inadmissible pursuant to K.S.A. 44-557.

Respondent argues that to the extent claimant was injured on September 27, 2000, her injury was temporary and left her with no permanent impairment as evidenced by the medical testimony as well as her ability to continue working for this respondent as well as for other employers up until 2003 at a comparable wage. And respondent agrees with the ALJ's conclusion that there is no basis in the record to award additional TTD benefits. Thus, respondent maintains claimant is not entitled to any further benefits in this matter.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings of fact and conclusions of law:

Claimant was injured in an accident on September 27, 2000 while working for respondent as she was helping a patient dress. According to claimant, the patient reached over her head and dug her fingernails into the claimant's upper back and pulled claimant's head sharply down into her knee. Claimant further testified she immediately felt pain and numbness in her right arm. While the existence of her accident is not in dispute, the nature and extent of her resulting injury and how her preexisting condition was effected by that injury is at the center of this dispute.

There is also a dispute as to the timeliness of claimant's claim. Just a few days after her accident claimant completed an Employee Incident Report.[2] This form indicates that claimant sustained an injury that resulted in complaints of pain with movement of her head. First aid was provided and claimant was directed, by the facility's director of nursing, to report to St. Francis Hospital's ER if the pain continued.[3]

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[1] ALJ Award (July 26, 2006) at 4.

[2] R.H. Trans., Cl. Ex. 1.

[3] *Id.*

As indicated above, this is not the only injury claimant has sustained. In 1974, claimant was diagnosed with radiculopathy and underwent a discectomy. Then in 1997, claimant experienced cervical complaints which lasted until 1998. The medical records indicate claimant was diagnosed with cervical spondylosis and according to claimant, her complaints resolved. But in April 1999, she again experienced radiculopathy at the C5 level and was diagnosed with a bulging disk and degenerative cervical disk disease. This medical history is important because respondent maintains that claimant's ultimate need for surgery was due to her preexisting degenerative condition rather than the 2000 accident while in its employ.

After her 2000 accident claimant was treated by Dr. Shari Quick and diagnosed with rotator cuff tendinitis and myofascial pain in the upper shoulder and lower neck along with osteoarthritis. Dr. Quick made this diagnosis with the assistance of an MRI and some earlier radiological studies done on claimant's neck. According to Dr. Quick, the old MRI showed degenerative changes, but when compared to more recent studies, there was no change in claimant's structural condition.

With the help of the medications and physical therapy prescribed by Dr. Quick, claimant continued to work her regular duties up until December 2000 when claimant's employment was terminated for her involvement in a patient's care. Nonetheless, her medical treatment continued past her termination.

In April 2002, Dr. Quick found the claimant to be at MMI and released her from care without any restrictions or a rating. This release was based upon a functional capacities evaluation which showed that claimant was able to perform her normal work duties. When deposed, Dr. Quick testified that had she been asked, she would have rated claimant's impairment as of April 2002 at 0 percent permanent partial impairment under the *Guides*.[4] She explained that claimant's range of motion was such that she qualified for no impairment. And under the DRE method of assigning impairment, she would have a 0 percent impairment because there was no documented herniation in claimant's neck nor any radiculopathy complaints.

Since claimant left respondent's employ, she has worked for at least 6 employers and earned a comparable wage.[5] Other than her last employment, in November 2003, claimant never left any of these employments for reasons associated with her 2000 injury. And at her last employer, Plaza West, she was attending an orientation program and

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[4] American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment*, (4th ed.). All references are to the 4th ed. of the *Guides* unless otherwise noted.

[5] One of these employers provided only part-time employment but her hourly rate was the same as full-time employment for other employers and there is no evidence that her physical condition limited her to part-time work.

experienced a headache. She left the orientation and was told she did not need to return.

These headaches, which prompted claimant's need to leave the orientation session, began in June 2003. At that point, claimant sought treatment through her own physician and was ultimately referred to Dr. Chawla, who in turn sent her to Dr. Charles Striebinger in April 2004. According to Dr. Striebinger, claimant did not disclose the fact that she had experienced prior neck problems in 1997 to 1999. He compared a 2001 MRI to a later one performed in 2003 and found there to be very little difference in claimant's structural condition. Nonetheless, based upon her complaints he recommended a discogram, which revealed a problem at the C6-7 level. He recommended and ultimately performed a 2 level fusion on June 4, 2004. Dr. Striebinger testified that claimant's disks were "bone on bone" and greatly deteriorated. He further testified that such degeneration is not usually due to trauma.

In September 2004, claimant was released to return to work. Claimant saw Dr. Striebinger again in November 2004 and March 2005. Both times he released claimant to return to work without restrictions other than the caution that she should not jump on trampolines.[6] Claimant has not worked since June 2003, and is not actively seeking employment. According to her, she is unable to lift even as much as a gallon of milk and is therefore unable to work. She has applied for Social Security Disability and began receiving those benefits in September 2005.

Dr. Striebinger agreed that the claimant's 2000 accident "could" have aggravated her preexisting degenerative disk disease. But, he added that he could not definitively say that the claimant's 2004 fusion surgery was due to the 2000 injury. He said that was a "presumptive call"[7] based upon claimant's recitation of the onset of her complaints.[8] Dr. Striebinger indicated that he had very few of the contemporaneous medical records from her earlier treatment and therefore he was unable to definitively comment as to the causal relationship between the surgery and the 2000 accident.

At her lawyer's request claimant was evaluated by Dr. Peter Bieri on May 25, 2005. He diagnosed her with degenerative disk disease and radiculopathy. He felt the claimant was at MMI and assigned a 25 percent whole person impairment based upon DRE Cervicothoracic Category IV. According to Dr. Bieri, claimant has a loss of motion segment integrity and multilevel neurological compromise in spite of her double fusion. He assigned restrictions that fall within the light physical demand category and include occasional lifting up to 20 pounds, frequent lifting up to 10 pounds, neglible constant lifting and limited

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[6] Striebinger Depo. at 16.

[7] *Id.* at 25-26..

[8] *Id.* at 12.

captive positioning. Dr. Bieri further testified that, based upon the vocational analysis by Dick Santner, claimant sustained a task loss of 26 percent.

Upon cross examination, Dr. Bieri conceded that claimant had a worsening of her symptoms in 2003, years after she left respondent's employ and after she had worked for others performing much the same job. He further conceded that it was this subsequent worsening of her degenerative condition led to surgery in 2004.[9] And that his 25 percent rating took into account the worsening of her condition and the resulting surgery. He agreed that as of April 2003, when Dr. Quick released claimant, at that point the claimant's range of motion studies supported a 0 percent permanent impairment rating.[10]

Claimant was also evaluated by Dr. Steven Hendler at respondent's request. According to Dr. Hendler, claimant disclosed her back problems dating back to 1974 which she said resolved, but denied any further injuries or complaints until 2000 when she suffered injury while working for respondent.

Dr. Hendler concluded the injury in 2000 amounted to a thoracic strain with minimal changes in her thoracic and cervical spine based upon the MRI's. He further observed that Dr. Quick released claimant in April 2002 and based upon that and the lack of treatment over the next 16 months, he believes claimant returned to her baseline condition.

Dr. Hendler also testified that claimant had no task loss based upon Mr. Santner's vocational analysis as he believed she was fully capable of performing all of the identified tasks. He reasoned that claimant had been working as a LPN since leaving respondent's employ in December 2000 and had, in fact, been returned to full duty by Dr. Quick as late as April 2002. For these reasons he remained confident that claimant had no task loss attributable to her work-related injury in 2000.

Claimant objected to Dr. Hendler's opinions and his testimony asserting that his opinions were based upon improper evidence, specifically a series of employer's accident reports which are inadmissable, based upon K.S.A. 44-557(b). That statute purports to exclude from evidence any accident reports generated by employers. Claimant maintains that because Dr. Hendler reviewed a number of accident reports, his testimony is based upon documents that are inadmissible. Thus, his testimony should be excluded.

During the course of his deposition, Dr. Hendler was asked the basis of his opinions and he indicated that his opinions are based upon his own examination, the medical records and the history provided to him by the claimant.[11] It appears from the entirety of

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[9] Bieri Depo. at 41.

[10] *Id.* at 27.

[11] Hendler Depo. at 17-18.

his deposition that the accident reports were used to confirm the existence of claimant's earlier history of injuries. And because claimant is, by all accounts, a poor historian, it does not seem unreasonable for Dr. Hendler to have done so. In any event, the Board concludes that his testimony makes it clear that he did not rely upon any of the employers' accidents reports in formulating his opinions. Rather, he formulated his opinions based upon the medical records and the claimant's own testimony. And he specifically testified that he only considered those reports for purposes of determining whether there were other reported work injuries.[12] Thus, under these facts, the Board finds it was appropriate for the ALJ to consider his testimony and opinions. Claimant's objection is sustained to exclude the reports and any reference to those reports or opinions that relied upon those reports but overruled as to those opinions that were given without regard to those reports.

Upon the ALJ's Order, the claimant was evaluated by Dr. David Clymer for purposes of obtaining a functional impairment rating and restrictions. Following a review of the pertinent medical records[13] and a physical examination, coupled with a discussion with the claimant, he concluded she was either a poor or reluctant historian. He found claimant's recitation of her medical history somewhat inconsistent with that reflected in the medical records. For example, she sustained a cervical whiplash injury in the mid-1970's, but indicated she had no previous cervical problems. Only upon direct questioning did she concede that she had, in the past, sustained a cervical injury. And when asked about her problems of headaches and neck pain in 1998 (as evidenced by medical records) she denied any recollection of those complaints, nor the treatment or recommendations made at that time.[14] In fact, he noted claimant's consistent failure to disclose these earlier physical problems in connection with this claim.

After his extensive review of the claimant's medical records, Dr. Clymer concluded that claimant had "some pre-existing problems of neck pain and headache prior to September, 2000."[15] He went on to say that "[i]t appears that this pre-existing condition was not adequately discussed with most of her treating physicians and, therefore, they have not commented whether this pre-existing problem in any way contributed to her subsequent subjective complaints. Clearly, I believe that it did."[16]

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[12] Hendler Depo. at 21.

[13] Pursuant to the ALJ's Order, Dr. Clymer was provided with Dr. Hendler's report but not with any of the accident reports which Dr. Hendler reviewed. Claimant does not request that Dr. Clymer's report or his opinions be excluded based upon K.S.A. 44-557(b).

[14] Clymer's Report dated May 1, 2006 at 2.

[15] *Id.* at 9.

[16] *Id.*

Dr. Clymer goes on to explain:

> I note that her injury on 09/27/2000 was initially not felt to be a neck injury at all. It was decribed as a thoracic strain, and evaluation and treatment was directed in that area. There was no comment with regard to a neck injury and initially no x-rays of the neck were obtained. When neck symptoms increased, x-rays and an MRI study were obtained about six months later. These revealed no significant changes when compared to her previous MRI study back in 1997.[17]

He goes on to conclude that the claimant suffers from multilevel degenerative disk disease in the cervical spine, multilevel degenerative spondylosis in the cervical spine, and associated myofascial pain syndrome and fibromyalgia, including the neck, back and upper extremities.[18] These symptoms are accompanied by more and more frequent headaches. He concluded that these problems "seem consistent with the findings noted back in 1997 and have progressed gradually and intermittently over time, in part related to various events" reflected in her history. And "[t]he work-related events on 09/27/2000 may have been a contributing factor in the progression of this process; however, I feel the contribution of those events is rather minor."[19]

Dr. Clymer ultimately assigned a 15 percent whole body permanent partial impairment as a result of cervical disk surgery and fusion and some loss of cervical range of motion. Of that 15 percent, he believed only 2-3 percent was attributable to the 2000 accident. He went on to say "[t]he remaining impairment is due to other gradually progressive multilevel degenerative disk disease and degenerative spondylosis. Any other possible additional impairment or subjective loss of function is related to the pre-existing lumbar spine problems and some more generalized myofascial pain syndrome, which I believe are both unrelated to these more recent work events."[20]

Dr. Clymer also offered a task loss opinion, suggesting that claimant "is able to perform all those 23 tasks with the exception that she is unable to perform tasks #2, #6, #7, #8, and #19 because the lifting in those tasks seems to [sic] excessive."[21] This opinion results in a 22 percent task loss.

The ALJ concluded claimant had satisfied the statutory criteria set forth in K.S.A. 44-520a(a) as the report of injury she completed shortly after her accident set forth the

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[17] *Id.*

[18] *Id.* at 10.

[19] *Id.*

[20] *Id.*

[21] *Id.*

basic information regarding her injury and because she testified that she believed that document constituted a written claim. The Kansas appellate courts have said that the purpose of the written claim statute is to place the employer on notice that a work-related accident has occurred so that the employer can investigate the circumstances of the accident and provide appropriate medical treatment. The accident report satisfied these purposes.[22]

The Board has considered the record as a whole and finds the ALJ's conclusion is well supported and should be affirmed. The employer's internal report of injury, while in a different form than that provided by the State of Kansas, nonetheless contains much the same information and thereby satisfies the statutory criteria.

Turning now to the major dispute between the parties, the ALJ adopted the functional impairment rating and apportionment offered by Dr. Clymer, the independent medical examiner and awarded claimant a 2 percent whole body permanent partial impairment. In making this finding, the ALJ noted that Dr. Clymer performed a thorough examination of the medical records and of the claimant. Thus, he found Dr. Clymer's report and the opinions contained therein to be the most credible of the doctors who examined claimant.[23]

The Board has considered the record as a whole along with the paties' arguments and concludes the ALJ's Award should be modified. When all of the medical testimony is considered, the Board concludes claimant suffered no permanency as a result of her 2000 accident that occurred while in respondent's employ. This decision is based upon the medical testimony of Dr. Quick, the treating physician who saw claimant over a 2 year period, and Dr. Bieri, claimant's examining physician. Both physicians testified that, based upon Dr. Quick's evaluation of claimant's range of motion, she had a 0 percent permanent impairment under the *Guides*, under both the range of motion model and the DRE model. While it is true that Dr. Quick did not render this opinion until she was deposed, nonetheless, her opinion was based upon her examination of claimant and the testing done during that last exam in April 2002. And when Dr. Bieri reviewed those test results and Dr. Quick's records, he agreed with Dr. Quick that claimant bore a 0 percent impairment as of the date she was released from medical treatment in April 2002.

Claimant went approximately 14 months without treatment or any physical complaints, until June 2003 when she sought treatment from her own physician for headaches. All the while, claimant kept working at jobs that were very similar in nature to her job with respondent. Although she did not maintain those jobs for any great length of

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[22] *Craig v. Electrolux Corporation*, 212 Kan. 75, 510 P.2d 138 (1973); *Pike v. Gas Service Co.*, 223 Kan. 408, 573 P.2d 1055 (1978).

[23] ALJ Award (July 26, 2006) at 3.

time, she testified as to the reasons for her termination and save one instance (when she left for a headache during orientation) her decision to leave each job had nothing to do with her physical condition. And those jobs paid between $13.00 and $14.50 per hour. Based upon this evidence, the Board finds that the claimant's subsequent treatment and neck surgery was unrelated to her 2000 accident. Thus, claimant demonstrated that she was capable of performing the same work and earn a comparable wage. The Board concludes claimant suffered no permanent impairment from her work-related injury. Therefore, the ratings and task loss opinions rendered by Dr. Clymer and Dr. Bieri are irrelevant as they relate to claimant's condition past April 2002.

The balance of claimant's arguments are moot as she is not entitled to a work disability under K.S.A. 44-510e(a). Similarly, the ALJ's decision to deny claimant's request for additional temporary total disability is affirmed as her subsequent need for neck surgery is found to be unrelated to her 2000 injury.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Brad E. Avery dated July 26, 2006, is modified to reflect a 0 percent permanent partial impairment.

All other findings are hereby adopted by the Appeals Board as if fully set forth herein to the extent they are not inconsistent with the above.

IT IS SO ORDERED.

Dated this _____ day of December 2006.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Paul D. Post, Attorney for Claimant
Michael L. Entz, Attorney for Respondent and its Insurance Carrier
Brad E. Avery, Administrative Law Judge